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Sex and the elderly

They should make their own decisions

The publication of a sensitive and helpful sex manual for the elderly by Age Concern is a good moment to take stock of doctors' understanding of the changes in sexual expression with age.[1] Kinsey and colleagues reported the sexual behaviour of vast numbers in their 20s but they had only three women and two men over the age of 80 in their sample.[2,3] Their conclusion—that three quarters of men aged 80 are impotent—came from a sample of four. Cross sectional studies may exaggerate the changes of aging by failing to control for loss of partner and the lesser importance attached to sexual pleasure by earlier generations. George and Weiler followed their samples for six years and showed that generational effects were greater than those from aging.[4] Bretschneider and McCoy found that 62% of men and 30% of women over the age of 80 (healthy residents of retirement homes in California) had recently had intercourse, while 87% and 68% had had physical intimacy of some kind.[5] The figures for women might have been higher were there not six women for every man in that population.

Cessation of sexual activity has been related to lower income, sexual guilt, lower importance of sex in the past,[5] late age of first intercourse,[6] mental illness, and subjective ill health in women.[7] As the sexual drive induced by testosterone falls continued physical intimacy is exposed to the winds of culture. One influence is the attitude of the doctor, whose failure to ask a patient about his or her sex life may be taken to indicate disapproval.

In this context the doctor has three obligations. Firstly, he or she should avoid or explain any treatments that may interfere with sexual activity. These range from drugs that increase erectile failure (such as thiazides and β blockers[8]) and lessen libido (such as benzodiazepines[9] and major tranquillisers) to surgery (such as indwelling catheters, pessaries, and rectal surgery). On the positive side postmenopausal hormone replacement therapy reduces vaginal atrophy. Secondly, he or she should explain to patients the changes that occur with age (as outlined by Masters and Johnson[10]). These include delay in arousal, with greater need of genital stimulation, reduced penile rigidity and vaginal lubrication, loss of the sensation of ejaculatory inevitability, and increasing anorgasmia. None of these changes need stop sexual contact, but the elderly may need "permission" to substitute mutual masturbation for penile penetration.[11] Thirdly, he or she should be aware of causes of sexual difficulty such as diabetes, arteriosclerosis, and dementia and of the treatments—ranging from the ban on intercourse and the sensate focus technique first described by Hunter[12] to the use of vaginal lubricants and penile implants. Dementia is often said to present with sexual disinhibition (which may be true of the frontal lobe dementias), but the more usual presentation of Alzheimer's dementia is with loss of libido. Local causes need to be discounted, including dyspareunia from pelvic infections and tumours. Fear of intercourse after myocardial infarction may need to be dispelled (anyone who can climb a flight of stairs is fit enough). Pain from arthritis may require judicious use of pillows and analgesia. The emphasis changes from a race to the summit of orgasm to a gentle wander around the foothills of massage, the peak being a bonus rather than a necessity.

The sexuality of the elderly is no place for the evangelist. The recognition that continued physical intimacy benefits both the psychological and physical health of the individual must be tempered by a willingness to allow elderly people to make their own decisions, unpressured by those who are younger.[13] The embarrassment of the patients will be overcome only if the doctor can take the lead in introducing the topic—which is not easy for those of us who were taught that elderly people don't do it.

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